The Journal of Values-Based Leadership

July 2019

Coexisting Values in Healthcare and the Leadership Practices That Were Found to Inspire Followership Among Healthcare Practitioners

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Abstract

Healthcare delivery in the United States has a storied history that has led the American public to expect that their Health Care Practitioners (HCPs) will personally and professionally enact values such as altruism, benevolence, equality, and capability. A progressive set of events that involves the implementation of the market-based solution in the Patient Protection and Affordable Care Act has led healthcare organizations to become increasingly concerned with a conceptually different set of values. It has become more necessary for healthcare organizations to dedicate attention to market values (e.g., competition; productivity) as they operate in an environment that is commonly described as a $3.3T industry. There is significant concern that important care values are being sacrificed as the U.S. health system becomes increasingly commercialized. It is also believed that HCPs are experiencing increasing levels of demoralization and burnout as a result of their inability to realize their personal and professional care value preferences. A qualitative investigation into the experiences of a selection of HCPs served to reveal how the administration in a large health system fosters compatibility among personal, professional, and market value priorities via an application of the tenets of values-based leadership. Study outcomes also feature implications for both the servant leadership and transformational leadership constructs.

Introduction

The American healthcare system has a rich and storied history that is rooted in a set of care-oriented values. These values are reflected in the mission statements of healthcare organizations (Graber & Kilpatrick, 2008), and the oaths that Healthcare Practitioners (HCPs) swear to uphold (Aquilar, Stupens, Scutter, & King, 2013; Gabel, 2013). As a result, the American public has rightfully come to expect that their healthcare institutions will maintain a patient-centered focus and that the HCPs who practice within these organizations will personally and professionally enact values such as altruism, advocacy, beneficence, capability, and equality (Graber & Kilpatrick, 2008; Moyo, Goodyear-Smith, Weller, Robb, & Shulruf, 2015; Schwartz, 1994).

Events like those that surrounded the expansion of employer-financed health insurance and the more recent implementation of the market-based solution in the Patient Protection and Affordable Care Act (PPACA) have connected healthcare organizations to a newer and conceptually different set of values. Market values emphasizing competition and productivity now appear as commonplace in a competitive environment that is often described as a $3.3 Trillion industry, one where it is increasingly difficult to distinguish between profit-driven healthcare entities and their not-for-profit counterparts (Cameron & Quinn, 2011; Evetts, 2011; Freidson, 2001; Gabel, 2013; Light, 2010; Relman, 2007; Thorpe & Loo, 2003). Regardless of the type of system they are managing, health system administrators must direct

significant attention toward the pursuit of market values in order to sustain organizational viability.

It is expected that HCPs will pursue their personal and professional preferences for *care* values, as they simultaneously work to uphold *market* values (e.g. productivity; efficiency), and it is they who are most likely to directly experience the consequences that emanate from such expectations. Given that few, if any, studies have sought to explore HCPs lived experience with expectations that they uphold care and market values, four physicians and four nurses were recently selected into a qualitative study that was intended to illuminate their experiences. While all eight of the participants do work within the same health system, the four physicians practice in discrete areas and the four nurses represent three different practice areas. Through the conduct of the study of the HCPs' experiences with expectations that they simultaneously uphold care and market values, it was found that their system administrators inspire followership among the HCPs via an adherence to the ethical and moral tenets of values-based leadership. The system's leaders demonstrate integrity and balance the needs of multiple stakeholders as they work to foster compatibility among personal, professional, and market value priorities.

Personal, Professional and Market Values in Healthcare

Values are considered to be one of the main catalysts of human behavior (Kluckhorn, 1951; Rokeach, 1973; Schwartz, 1994) and are central to most organizational phenomenon (Connor & Becker, 1994). In the study of coexisting values in healthcare, human values were conceptualized as existing at the individual (i.e. personal) and collective (i.e. professional; organizational) levels (Rokeach, 1973; Schwartz, 1994). Values serve as guiding principles in the life of an individual and/or social entity and as such, all value types (personal, professional, and market) were treated as sources of goal-based motivation (Kluckhorn, 1951; Maslow, 1959; Rokeach, 1973; Schwartz, 1994; Williams, 1968).

This inquiry was predicated on the view that *personal* values are a complex proposition involving cognition, affect, approval, and selection of behavior (Kluckhorn, 1951; Parson & Shills, 1951; Schwartz, 1992). Through the course of the study, it was confirmed that the personal value preferences of many of the participants informed the choice to become an HCP and that personal values were further refined through common socialization processes (e.g. medical training; patient interaction). *Professional* values are commonly conceptualized as guiding the actions of a collective and are believed to promote smooth interactions among and between the members of the various medical professions (Arnold, 2002; Schein, 2010). The professional values of HCPs are reflected in public declarations that doctors and nurses make, and therefore commit to uphold. A modern-day version of the Hippocratic Oath is included as Appendix A and the American Nursing Association's Code of Ethics can be found in Appendix B. Studies and manuscripts that are based on public declarations and notions of medical professionalism emphasize altruism as an overarching professional value. Benevolence, advocacy, non-maleficence, compassion, and human dignity values are also commonly referenced as being integral to the delivery of patient-centered quality care.

Much of the research that involves the study of HCP values is based on the common belief that it would be nearly impossible to make a clear conceptual distinction between those values that are personal and those that are professional (Dose, 1999; Moyo, et al., 2015; Pipes, Holstein, & Aquierre, 2005; Thorpe & Loo, 2003). In practice, HCPs may also experience difficulty drawing such a distinction (Dose, 1997). The idea that an HCPs' personal and

professional values are inextricably linked was reflected in the words of one of the research participants when he said, "I think they're so ingrained, to be able to separate one from the other, would be very hard" (D.9). In their effort to identify the *personal and professional* values that are most relevant to HCPs, Moyo, et al. (2015) found the values of altruism, fairness, and capability to be predominant among HCPs and the interviews with those who participated in the study confirmed their preferences for such values.

For HCPs, their personal and professional values function as interpretive criteria. As such, they form the basis for justifying the actions they take and judging the events that they may encounter (Kluckhorn, 1951; Rokeach, 1973; Williams, 1968). The investigation was further based on a general agreement that certain values may either conflict or be compatible depending on the degree of perceived similarity (Meglino & Ravlin, 1998; Parsons & Shils, 1951; Schwartz, 1994). While it is possible that values may be reprioritized for the purpose of selection of action (Parsons & Shils, 1951; Rokeach, 1973), all eight of the participants expressed a preference for giving priority to the pursuit of care values over any market values that their organization may emphasize.

Cameron & Quinn's (2011) research on organizational effectiveness indicators led them to the development of the Competing Values Framework. Their framework features an identification of four discrete values that exist across a range of organizational types and "the core values that dominate a market type of organization are competitiveness and productivity" (Cameron & Quinn, 2011, p. 44). According to these researchers, the primary objectives of market-oriented organizations involve the pursuit of "profitability, bottom-line results, strength in market niches and a secure customer base" (Cameron & Quinn, 2011, p. 44), and they found that organizations began to place an increased emphasis on *market* values in the late 1960s, as they faced "new competitive challenges" (Cameron & Quinn, 2011, p. 44). The timing of the increased emphasis on market values such as competition and productivity coincided with the arrival of national health insurance and an expansion of employer-financed health insurance (Freidson, 2001). The resulting increase in the reliability of payments for medical services attracted private investment from those seeking profit (Freidson, 2001). The trend toward the increased presence of profit-seeking entities (e.g. insurance and pharmaceutical companies; the makers of medical devices) has been augmented by a public policy agenda that led up to the market-based solution found in the Patient Protection and Affordable Care Act (PPACA).

While it is acknowledged that the PPACA has served to extend insurance coverage and improve health outcomes (Frean, Gruber, & Sommers, 2017; Shartzer, Long, & Anderson, 2016; Sommers, Gunja, Finegold, & Musco, 2015), the policy also fosters a fee for service and insurance reimbursement payment structure where providers are motivated to deliver as many services as can be justified and insurance companies seek to protect bottom-line profitability (Larkin, Swanson, Fuller, & Cortese, 2016). The weight that is placed on patient satisfaction in the value-based purchasing provisions of the PPACA and the related public reporting of patient experience data on the Centers for Medicaid and Medicare (CMS) website, has served to further advance the attention directed towards the pursuit of market values. Hospitals' reimbursement payments are linked to the patient experience data (Cleary, 2016; Junewicz & Yougner, 2016) and this creates an incentive for hospitals to encourage their HCPs to make decisions that are consistent with increasing patient experience scores (Zgierska, Rabago, & Miller, 2014). The public reporting of patient experience data for individual physicians and hospitals and the expanded use of this data by entities that pay for healthcare

spurs competition among providers and the systems within which they work. It has also been asserted that the current emphasis on patient satisfaction has exacerbated the role of patient as consumer (Junewicz & Yougner, 2016; Zgierska, Rabago, & Miller, 2014).

The presence of profit-driven entities, the reliance upon markets in healthcare reform and emergence of conveniently accessible and less costly alternatives to traditional care models have made it necessary for health system administrators to focus on market issues in order to ensure system viability and promote the long-term survival of the entities over which they have stewardship (Evetts, 2011; Handel & Gefen-Liban, 2003; Heifetz, 1994; Light, 2010; Martin, Armstrong, Aveling, Herbert, & Dixon-Woods, 2015; Meglino & Ravlin, 1998). Market values emphasizing competition, productivity, cost efficiency, and risk-taking now undergird the delivery of care in most healthcare organizations (Evetts, 2011; Handel & Gefen-Liban, 2003; Relman, 2007).

The trend towards a market-based health system which celebrates the aforementioned values has caused some to posit that the values which traditionally guided the practice of medicine are irrevocably receding as the American healthcare system becomes increasingly commercialized (Freidson, 2001; Melia, 1995; Relman, 2007). Furthermore, some have raised significant concerns regarding the social commitment that health systems have made to their patients and to society at large (Freidson, 2001; LeDuc & Kotzer, 2009; Relman, 2007; Sikka, Morath, & Leape, 2015).

Studies that compare the conventional values found in healthcare to those of the market suggest that HCPs and healthcare executives have different value orientations (Graber & Kilpatrick, 2008; Handel & Gefen-Liban, 2003; Thorpe & Loo, 2003). HCPs are likely to be sensitive to imbalances between the values espoused in their organizational mission statements (see appendix C for examples of such statements), and those values that are practiced or emphasized by their leadership (Argyris & Schon, 1974; Meglino & Ravlin, 1998; Senge, 1990). System leaders may therefore experience problems when they attempt to infuse market values into organizations wherein the members (e.g. HCPs) prefer the pursuit of values such as altruism and equality over those that promote organizational self-interest.

The problematic consequences of this coexisting values phenomenon may be most directly experienced by HCPs. In instances where their personal and professional care values conflict with those of the market, it has been posited that these HCPs may experience demoralization and feelings of subjective incompetence (de Figueiredo, 2015; Gabel, 2013). HCPs may ultimately experience burnout when they are unable to reconcile their personal and professional values (e.g. fairness; altruism) with opposing values (e.g. productivity; power) they encounter in their work environment (Maslach & Leiter, 1997; Schwartz, 1994).

Burnout has been found to be prevalent in both doctors and nurses (Bodenhemer & Sinsky, 2014) and has been correlated with poor patient outcomes (Kriemer, 2018). According to Feldman (2018), burnout among physicians is increasing across a range of practice areas, and those who suffer from its ill effects have significantly higher rates of depression, alcohol abuse, drug abuse, and suicide (Lacy & Chan, 2018). Efforts on the part of leadership to address the systemic issues that contribute to HCP burnout offer hope for addressing what is an otherwise disturbing state of affairs (Kriemer, 2018; Lacy & Chan, 2018; Laskowski-Jones, 2016).

Methodology and Methods

The investigation into the expected coexistence of personal, professional, and market values in a healthcare setting was predicated on a philosophy which suggests that, as humans, HCPs are interpretive beings who attach meaning to their lived experience (Dowling, 2007; Holloway & Wheeler, 2013; Racher & Robinson, 2002). Since the consequences of the expected coexistence of the aforementioned values in healthcare are directly experienced by HCPs, it was decided that their narrative accounts of lived experience represented a useful source of data for deepening our understanding of the significance of the phenomenon and how it manifests.

Upon individual confirmation of practical experience with the ordinary coexistence of personal, professional and market values within the context of their practice, a total of eight HCPs were selected for the study. The three male physicians who participated in the study practice in the areas of cardiology, oncology, rheumatology, and the one female physician participant is a family medicine provider. Each of the four physicians is at a different stage of their respective career. The four nurses who shared their experiences are all female and they represent the practice areas of endocrinology, primary care, and rheumatology. Three of the nurse participants are close to retirement and the one nurse participant who practices in area of endocrinology is at a far earlier stage of her respective career. The role of all study participants involves direct patient contact. A primary aim of this research into a coexisting values phenomenon was to generate information that could be useful to those who might see their own experiences in those of the research participants and/or anyone who might operate in a context that is comparable to the one in which the research took place.

The study participants work for a large health system that delivers care across a sizeable geographic area of the Western United States. The system is comprised of several hospitals and an extensive network of clinics located in both densely and sparsely populated areas. The health system's revenues are primarily derived from third-party insurance payments for the products and services delivered by the system and its HCPs. The majority of those who participated in the study have regular interaction with vendors (e.g. the makers of medical devices; pharmaceutical companies) whose own revenues are dependent on the health system within which the HCPs work. Dyadic relationships exist among several of the HCPs who participated in the study and such relationships stem from working in the shared practice area of rheumatology.

The methods that were used to conduct the study involved semi-structured interviews that were designed to allow each of the eight participants to describe *what* their experience has been with the phenomenon and *how* they interpret the expectations that personal, professional, and market values can coexist within the context of their practice. Participant interviews were recorded, transcribed, and analyzed. The analysis of the data derived from interviews involved an integration and application of procedural steps developed by van Manen (1990) and Colaizzi (1978). Participant statements that were identified as being most relevant or significant to the study were isolated and analyzed in order to pursue a "deepened and more reflective understanding" (van Manen, 1990, p. 86) of the meaning behind the stories and anecdotes that were offered. The arrival at a set of themes that are representative of the common experiences of the study participants was informed by Saldana's (2009) "analytic process of winnowing down themes" (p. 140) to the essential aspects of the investigated phenomenon.

The qualitative inquiry into the HCP's experience with the expected coexistence of care and market values was conducted with an adherence to the trustworthiness and authenticity quality criteria proposed by Lincoln and Guba (1985; 1986a). The intent was not to realize generalizability of findings, but rather, transferability, whereas the findings are specific to the time and context in which the research took place and should therefore be judged in terms of their applicability to other settings. The study was conducted with the goal of providing a fair and balanced representation of the range of values that are present within the context of healthcare delivery and a strict adherence to the protocols for conducting human subjects research as prescribed by the United States Department of Health and Human Services. In order to protect the confidentiality of the participants, they are referred to as Doctors A, B, C, and D and Nurses E, F, G, and H. Alphanumeric codes (e.g. A.39; G.52) are in place at the conclusion of each direct quote in order to ensure the confirmability of statements that were offered by study participants.

Findings on the Values-Based Leadership Practices that Inspire HCP Followership

While the study was not designed to specifically investigate the leadership practices of those who operate the health system in which the research took place, it is apparent that its administrators inspire followership among those HCPs who participated in the study. The integrity that is exhibited the health system's leadership is reflected in the words of Nurse F who described those who have ascended to positions of authority as individuals "who actually want to do the right thing and take care of the patient" (F.33). Like others who participated in the study, Nurse F named specific leaders whom she admires, and she considers herself fortunate to work with such "stellar people" (F.32). The anecdotes and stories of lived experience shared by the participants indicate that the system's administrators practice values-based leadership by 1) providing support that enables the HCPs to realize their personal and professional value imperatives; 2) promoting congruence between organizational values and the personal and professional values of the system's HCPs; and 3) positioning HCPs in leadership roles and engaging with the HCPs as partners.

Leadership Support for the Realization of Personal and Professional Care Value Imperatives

Through conversations with the research participants, it became clear that the system's leadership provides support and engages in advocacy that affords the HCPs the opportunity to enact their personal and professional value priorities. When asked if he has experienced the expected coexistence of personal, professional, and market values as being compatible, Doctor C responded by describing how system administrators practice "service leadership" (C.27) and he identified specific leaders who enact policy that makes "life easier on the docs" (C.25). He provided a specific example where he was recently allocated two medical assistants who are responsible for the maintenance of electronic medical records (EMRs). Doctor C expressed an appreciation for never having to touch the computer while a patient is in the room and he views the assistance he receives as conducive to his personal preferences for efficiency and being more present with his patients. During her interview Nurse F also discussed the benefits of receiving assistance with the upkeep of EMRs by stating, "we are making eye-to-eye contact which is probably [something] in healthcare [that is] becoming lost" (F.37).

In their study of physicians and the amount of time they spend directly interacting with patients, Asan and Montague (2012) found that when physicians are responsible for the upkeep of EMRs, they spend 49.6% of their time on the computer. In a national survey of physicians, 87% of those who participated identified paperwork and administrative responsibilities as being a leading cause of work-related stress and burnout (Bodenherimer & Sinsky, 2014). A team-oriented approach to documentation and the maintenance of EMRs has been identified as one of the primary ways in which healthcare leadership can improve revenues and their system's capacity to manage a larger panel of patients, while also improving the work life of clinicians and staff (Bodenherimer & Sinsky, 2014).

Through the course of his long career Doctor C has always felt that it is very important that nobody be turned away and he has sought to work in systems where people have equal access to care. Doctor D spoke to how another support structure in the system where he and Doctor C currently work allows for the provision of universal access to care:

> *What I love about this group [system] is that I treat whoever walks in the door; I treat them all the same way. If they don't have insurance, or they are under-insured, we have a team that makes sure we can get that covered* (D.8).

The system where the investigation into coexisting values took place is one where Doctors C and D are able to realize their shared preference for universalism (i.e. equality). Both of these specialized care physicians perceive their current system as distinct from others that have a more pronounced orientation towards revenue enhancements.

Doctor B is a family practice provider, and through dialogue it became quite clear that, she values the delivery of a comprehensive level of care that leaves her patients feeling satisfied with their experience. When asked about her experience and any consequences that emanate from the expected coexistence of values within the context of her practice, she responded by saying that her "biggest concern is the push for black and white productivity" (B.61). When the amount of time that Doctor B spends with her patients recently resulted in the threat of a pay cut, a high-level physician leader who was unknown to her provided support by advocating on Doctor B's behalf, and she was therefore able to maintain her current salary. At the time of her interview, Doctor B was looking forward to an upcoming meeting with the system's leadership where she would have the opportunity to discuss, and potentially rectify, perceived imbalances between her personal and professional value preferences and the market values that the system's administration emphasizes.

The findings from the investigation into coexisting values in healthcare are in keeping with other studies that have found general practice physicians to be among the HCPs who are most susceptible to burnout (Bodenhemer & Sinsky, 2014; Lacy & Chan, 2018). Support and advocacy from competent leadership, like that which was described by multiple study participants, has been found to reduce stress and incidents of burnout across all practice areas (Lacy & Chan, 2018; Shanafelt, et al., 2015). The narrative accounts of experience provided by the HCPs during this study suggest that such leadership also affords them the opportunity to more fully enact their care value preferences.

Leadership Practices that Promote Value Congruence

The importance of a supportive environment and how it contributes to perceptions of values congruency is reflected in a statement that was offered by Doctor B. She stated that "It's truly important to me that my organization supports me and that we have the same values about

what we want for patient care" (B.47). Her positive experiences with the leadership in the system has led her to believe that the system has the right intentions. She experiences congruency between her preferences for the delivery of comprehensive care, fairness and the upholding of human dignity, and the values that the system's leadership ultimately gives priority to (Argyris & Schon, 1974).

Doctors C and D both described their specialized practice within the larger system as being akin to a private practice. Doctor D expressed specific gratitude for the administration's willingness to allow him to pursue his personal preference for autonomy:

> *When you join a hospital system, it could be viewed as a big bureaucracy with a lot of people telling you what to do and I would not care for that. I think I've been given incredible freedom and flexibility...to do the research I'm passionate about, but still [I]am running my own practice within a hospital system... I think I get the best of both worlds* (D.5).

The freedom Doctor D is afforded is a source of values-based motivation. He considers himself fortunate to work in a situation he described as generally rare for those who practice in larger systems. Doctor D also described the system's compensation practices as "very-very good" (D.54) and conducive to his sworn commitment to do no harm. He expressed gratitude for having a compensation system that does not incentivize over treating patients and he believes that the system's compensation practices remove any subtle or sub-conscious pressure that those in private practice might be subject to.

While Nurse G did speak to some degree of sacrifice in autonomy and an increase in productivity pressures for herself and the physician she works with as they collectively transitioned to the large health system, she also spoke of experiencing alignment with the care values and goals that their newer system emphasizes. Nurse G experiences little in the way of consequences when she takes extended amounts of time to exercise her preference for guiding and supporting her patients as they come to terms with life-changing diagnoses. At the close of her interview, Nurse G was asked if there was anything else that she thinks should be known about the coexisting values phenomenon. She replied by saying, "I really love my job. [I] kind of found my dream job which is something that I think a lot of people don't get to say" (G.25).

Congruency between the personal values of an organizational member and those that an organization embodies is commonly referred to as person-organization fit (P-O fit) and its general benefits are well established. When personal and organizational values are in alignment, organizational members have been found to realize a higher degree of satisfaction, a reduced intention to quit, and are more likely to put forth extra effort (Edwards & Cable, 2009; Kristof-Brown, Zimmerman, & Johnson, 2005). In a recent study on values congruence that was specific to heath care, Risman, Erikson and Diefendorff (2016) found that nurses' perceptions of values congruence were a significant predictor of their job satisfaction and the quality of patient care.

There are mutually reinforcing benefits that extend from the values-based efforts put forth by the system's HCPs, and this finding was reflected in a significant statement offered by Nurse F, who said, "I feel like they've allowed me to practice what my core values are. I think they see some value in the fact that I really do care about the patient and I'm glad to go the extra mile when needed" (F.40). The leadership in the health system in which the study participants practice appears to understand that P-O fit can be a significant source of competitive

advantage and that organizational effectiveness is enhanced when they give their HCPs the freedom to enact their personal and professional care value preferences.

Peer Leadership and a Partnership with System Administrators

In the conduct of the study, it was also found that the system is one where the administrative leadership seeks to foster a close working relationship with their HCPs. According to Doctor A:

> We have a system that works very well. We have physicians working with administrators to ensure good access to high-quality care, that is innovative...we [also] have physicians who are in administrative roles and are doing a lot of strategic planning (A.36).

The practice of having physicians in leadership roles is in keeping with the recommendations that Chatfield, Byrd, Longenecker, Fink, and Gold (2017) offer in their study of efforts to achieve system-wide transformation in the nation's top performing academic medical centers. According to these researchers, physician involvement in leadership is the best way to foster their buy-in, and the practice helps to "ensure that leadership is seen as a partnership between administration and care providers" (Chatfield, et al., 2017, p. 377). Chatfield et al. (2017) also identify the practice of developing strategy in conjunction with those who will enact it as essential to the realization of a shared vision.

Nurse E echoed the call for peer leadership and opined that if care and market values are to coexist, there "needs to be more *nurse* leaders" (E.69), as it is they who best understand "the pulse of what's happening on a day-to-day basis" (E.69). Nurses are the largest segment of the healthcare workforce and they spend the greatest amount of time delivering patient care (Institute of Medicine, 2011). The idea that Nurse E put forth is reflected in others' appeals for nurse leadership. The Institute for Medicine (2011) calls for nurses to "act as full partners with other health professionals and to lead in the improvement and redesign of the healthcare system and its practice environment" (p. 23), and Bisognano (2016) sees nurse leaders as "crucial to healthcare system transformation" (p. 423).

In their case study of the Affordable Care Act and the complexity associated with healthcare reform, Larkin, Swanson, Fuller and Cortese (2016) call for transformational leadership at all levels of practice. Larkin et al. (2016) posit that, like the administrators under whom they work, HCPs should view themselves as "system stewards...and realize that they have the power to do something about" (p.137) the current status of the broader health system. By engaging with one another, transformational leaders at all levels of healthcare will be better equipped to make sense of complexity and "react productively and efficiently to system changes" (Larkin, et al., 2016, p.137).

Conclusion

The investigation into the expected coexistence of values within a large health system served to reveal the localized and context specific experiences of a select and relatively small group of HCPs, and with that come limits to the generalizability of the leadership findings. While research into the perceptions of a larger set of HCPs and the use of alternative research methodologies (e.g. hypothetical /deductive; grounded theory) are certainly warranted, the aim of the current inquiry was to further illuminate lived experience with a coexisting values phenomenon that is both complex and commonplace; and provide an additional avenue through which we might be able to better understand and identify with those who operate at the nexus of healthcare delivery.

The findings from the current investigation revealed a significant difference in terms of how some participants described their experience with administrators in organizations with which they were affiliated earlier in their careers; those previous administrators exhibited behaviors that were interpreted as being devoid of compassion and antithetical to the personal and professional values that the HCPs prefer to enact. The findings from this qualitative inquiry suggest that the current system's administrators embody values that reflect the value priorities of the HCPs who participated in the study. Their leadership appears to value and prioritize integrity, while demonstrating care for those who care for others. They practice service leadership, as they work to "assure that people get the resources they need" (Autry, 2001, p. 20) and make sure the HCPs' highest priority needs are addressed (Greenleaf & Spears, 2002).

While it was clear from the study that all organizational members (HCPs and system administrators alike) are expected to enact market values, such values do not seem to have permeated the system's culture. From the feelings of organizational support and the value congruence that study participants described, it is evident that the vast majority of the participants experience their system in ways that are more in keeping with Cameron and Quinn's (2011) notion of a clan (vs. market) culture, wherein "shared values and goals, cohesion and participative-ness" (p. 46) are the norms. By opening themselves up to the perspectives of those who operate at the nexus of care delivery, the system's leaders are better able to understand the organizational challenges that stem from the simultaneous pursuit of care and market values.   Through the conduct of the investigation into coexisting values within the context of a large health system, it became clear that its administrators are proponents of a shared leadership philosophy and that there are mutual benefits that can be derived from such an approach to leadership.

Recent calls for transformational leadership at all levels of heath care practice extend from ongoing issues and changes within the U.S. health system. As new models of care delivery evolve (e.g. perioperative medical home), future research should be directed toward the leadership roles that HCPs are fulfilling (Desebbe, Lanz, Kain, & Cannesson, 2016). Personal and professional values such as altruism, compassion, and fairness appear as being quite conducive to an ethical and moral approach to building followership within the realm of healthcare. We would do well to better understand how our HCPs' pursuit of such values might be contributing to their leadership effectiveness and the efficacy of interprofessional care teams. It is also important to consider leadership opportunities as another avenue through which HCPs can more fully realize their care value priorities.

Movement toward a nationalized health system like that which exists in most developed democracies could likewise serve to allow our HCPs the opportunity to more wholly realize their personal and professional value imperatives. However, the abolition of the PPACA could further curtail our HCPs ability to realize important care values, as the U.S. currently ranks among the 22 (out of 194) World Health Organization (WHO) member nations who have achieved a greater than 80% rate of universal health coverage (World Health Organization, 2018). While the WHO does support the realization of universal coverage by engaging in health innovation (World Health Organization, 2019) and "has been working towards strengthening (national) health systems to make them efficient, effective and responsive" (p. 46) since the time of its inception (World Health Organization, World Intellectual Property Organization and World Trade Organization, 2013), the WHO does not appear to distinguish any of its member nations (or broad health systems) in terms of their propensity to innovate.

It is important to consider that the joint emphasis on competitive market values and reformed payment structures that has accompanied the implementation of the PPACA can serve to catalyze innovative solutions that promote access, contain costs and bring improvements to care quality (Christensen, Baumann, Ruggles & Sadtler, 2006; personal correspondence; Tsai & Jha, 2014).

Fairly recent events at the national and state level have raised questions with regards to the public's willingness to a support a single-payer system (e.g. Colorado[1]), and the fiscal feasibility of tax-based healthcare reform (e.g. Vermont[2]). The ongoing and multi-faceted debate surrounding healthcare reform has caused stakeholder (e.g. HCPs; administrators; patients; taxpayers) values to materialize more profoundly and this has precipitated varying levels of conflict on multiple fronts. During times such as these, we should keep in mind one of the central tenets of transformational leadership theory, as posited by James Macgregor Burns (1978). He suggests that there are benefits that can be derived from exposure to conflicting demands, goals, and values, and states that the reciprocated illumination of values enables us to evaluate one another's perceptions and collectively move towards higher levels of motivation and moral purpose. Future efforts to drive efficiency and effectiveness in the broader heath system should involve an application of leadership theories that acknowledge a competing values perspective, as we cannot afford to disregard the potential for values conflict within the realm of healthcare, nor can we compromise the moral and ethical obligations to its multiple stakeholders.

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[1] In 2016, Colorado voters overwhelmingly rejected a ballot measure to enact a tax-funded single-payer system in which all Coloradans would have gained health insurance.

[2] In 2014, then Governor Peter Shumlin abandoned a signature effort to implement a single-payer system in Vermont amid an acknowledgment that the tax-based funding for such a system could be too much of a burden on the state's economy.

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About the Author

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Appendix A : A Modern Hippocratic Oath by Dr. Louis Lasagna
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I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow;

I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body, as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection hereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

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Provision 1: The nurse practices with compassion and respect for the inherent dignity, worth and unique attributes of every person.

Provision 2: The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population.

Provision 3: The nurse promotes, advocates for, protects the rights, health, and safety of the patient.

Provision 4: The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care.

Provision 5: The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.

Provision 6: The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.

Provision 7: The nurse, in and all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy.

Provision 8: The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.

Provision 9: The profession of nursing, collectively through its professional organizations, most articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy.

Appendix C: Examples of Health System Mission Statements

"To be a trusted partner, empowering healthier lives through care and compassion."
— **Lee Health, Lee County, Florida**

"Working with our members and other stakeholders, the Association will transform Virginia's health care system to achieve top-tier performance in safety, quality, value, service, and population health. The Association's leadership is focused on: improving access to care; continuing to improve health care safety, quality, and service; promoting a vibrant, high-value health care system; and, advancing population health to promote health and economic opportunity for all Virginians."
—Virginia Hospital and Healthcare Association, Glen Allen, Virginia

"We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities."
—Trinity Health, Livonia, Michigan

"The Mission of Berkshire Health Systems is to improve the health of all people in the Berkshires and surrounding communities, regardless of their ability to pay."
—Berkshire Health Systems, Pittsfield, Massachusetts